TREATMENT PLAN

Date_____ **Patient** _____

Diagnosis/Clinical Impression [ ] See attached Dx Sheet

_____

_____

Recommended Spinal / Extremity Manipulation, Therapy, and Frequency:

[ ] CMT12 [ ] CMT34 [ ] CMT5 [ ] Extremity Manip [ ] Manual Therapy Tech

Daily _____ 2 x wk _____ 1 x mo _____ 3 x wk _____1 x wk _____

[ ] Hot Packs _____ [ ] Interferrential _____ [ ] Ultrasound _____ [ ] Cold Packs _____

[ ] Intersegmental Mob ___ _____ [ ] Vibro-percussion _____ [ ] Massage _____

Rehab: [ ] Home Cervical Traction Device

[ ] Cervical [ ] Shoulder [ ] Elbow [ ] Hand [ ] Thoracic [ ] Lumbar [ ] Hip [ ] Knee [ ] Ankle

[ ] 3 Week Program (modified) [ ] 6 Week Program (typical) [ ] 9 Week Program (extended)

Emphasis to be placed on the [ ] Right Side [ ] Left Side **Estimated Start:** _____

Structural Support:

[ ] Cervical Pillow _____ [ ] Cervical Collar Soft _____ [ ] Side Kick Low Back _____

[ ] Lumbar Cushion _____ [ ] Lumbar Belt Soft _____ [ ] AquaSteps _____

Extremity: [ ] Shoulder _____ [ ] Elbow ____ [ ] Wrist _____ [ ] Knee ____ [ ] Ankle _____

[ ] Foot Balance Examination Scheduled in _____ **to evaluate for possible fitting of :**

[ ] Bio-Balance _____ [ ] Foot Levelers _____ [ ] Sole Supports _____

Short Term Goals:

Reassessment _____ week(s)/month(s) _____ % Improvement within _____ weeks.

Long Term Goals:

_____ % Improvement [ ] See Initial Exam and Report of Findings Goals [ ] Other_____

Reports: Yes No Due Date _____ Type: [ ]Att-Initial PI [ ]WC-C9 [ ] IME [ ] Initial ROF-Fam Doc,

Follow Up Evaluation and Procedures:

1. [ ] Digital Range of Motion Examination. …..[ ] Cervical _____ [ ]Lumbar _____

2. [ ] Physical Performance / Muscle Testing [ ] Upper Body _____ [ ] Lower Body _____

3. [ ] Algometer Pressure Point Testing ……[ ] Cervical _____[ ] Thoracic _____ [ ] Lumbar _____

4. [ ] Fibromyalgia 18 Point Testing ……. _____

5. [ ] Body Fat Skin Caliper Testing ……. _____

6. [ ] Pain Disability Index Testing ……. [ ] Vernon Mior – Neck Pain _____

[ ] Revised Oswestry – Low Back Pain _____

7. [ ] Thermeter Testing ……..[ ] Cervical _____[ ] Thoracic _____ [ ] Lumbar _____

8. [ ] Examinations …….. [ ] Re-Examination _____ [ ] Progress Report _____

9. [ ] Nutritional Evaluation …….. [ ] 30 min outside regular adjust care. _____

Other: _____

Restrictions:

Bed Rest _____ Don't Force Guarded Movement _____ Athletic Activity _____

Cervical: Flexion _____ Extension _____ Lateral Flexion _____ Lack of Sleep _____

Lumbar: Sitting _____ Bending _____ Stooping _____ Lifting _____ Other _____

Other Restrictions: _____

Special Instructions:

Home Instructions: Ice_____ Moist Heat Only _____ Hot Soaking _____ Lying On Back, Legs Up _____

Sleeping Position _____ Cervical Pillow _____ Wearing Supports _____ Auto position _____ Lifting_____

Changing Positions: Bed _____ Auto _____ Seated Position _____ Other _____

Patient Education: Spinal Health Workshop _____ Other _____

_____

Patient Employment:
Off Work: From _____ To _____ Home: Rest _____ Bed Rest _____ Guarded _____
Light Duty: From _____ To _____ Description _____
Restrictions: [ ] None [ ] No Lift object heavier than ____ lbs. [ ] No Climbing Ladder [ ] No Heavy Pushing or Pulling [ ] No Work w/hands above shoulder level [ ] No repeated or sustained bending over [ ] No repeated or sustained working in distorted positions [ ] No rough driving or riding (vehicle, road or otherwise [ ] _____
_____

Lifestyle/ Diet Modification / Nutritional Support:
[ ] None Recommended [ ] Recommendations: [ ] High Protein / Low Carbohydrate [ ] Increase Fluid Intake _____ [ ] Daily Walking _____ [ ] Reduce fat Intake _____ [ ] Increase Fiber Intake _____
[ ]Multiple Vitamin _____ [ ] Calcium Supplement _____ [ ] Glucosamine Sulfate _____
[ ] Disc Support _____ [ ] Vitamin C _____[ ] Other _____
:_____
_____

Referral for Consultation :

_____ None recommended at this time.

_____ Referral to _____
For:
_____
_____

Scheduled / / Time: : AM/PM
Provider_____
Confirmed with Patient
By _____

ADDITIONAL DIAGNOSTIC TESTING

[ ] None recommended at this time
[ ] Following additional studies recommended

Diagnostic Imaging
_____ Arthography
_____ Computer Tomography (CT)
_____ Contrast Enhanced CT
_____ Contrast Enhanced MRI
_____ Diagnostic Ultrasound
_____ Discography
_____ Fluoroscopy
_____ Magnetic Resonance Imaging (MRI)
_____ Positive Emission Tomography (PET)
_____ Radionuclide Bone Scan
_____ Thermography
_____ Videofluorography
_____ Other_____
_____ Other_____
Scan _____

Scheduled / / Time: : AM/PM
Provider_____
Confirmed with Patient / /
By_____

Electrodiagnostics
_____ Brain Electrical Activity Mapping
_____ Brain Stem Auditory Evoked Response
_____ Electroencephalography
_____ Electronystagmography
_____ EMG (Needle)
_____ Magnetoencephalography
_____ Nerve Conduction Velocity
_____ Peripheral Electrodiagnostics
_____ Somatosensory Evoked Potential
_____ Surface Electrode EMG
_____ Visual Evoked Response
_____ Other

Rehabilitation
_____ Evaluation
_____ Referral

Laboratory
_____ CBS
_____ ESR
_____ SMAC12
_____ SMAC24
_____ Urinalysis (DS)
_____ Urinalysis (Micr)

Profiles
_____ Anemia
_____ Cardiac
_____ Hypertension
_____ Joint
_____ Lipid
_____ Liver
_____ Metabolic _____ Bone
_____ Pancreas
_____ Pregnancy
_____ Skeletal Mus
_____ Thyroid
_____ Urinary Tract
_____ Other

Remarks :
_____
_____
_____
_____

Treatment Plan